		(X2) MULTIPLE CO		(X3) DATE SURVEY	
		A. BUILDING	01	COMPLETED 09/18/2012	
155677		B. WING		09/18/2012	
NAME OF F	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP CODE	
BELL TR	ACE HEALTH AND	LIVING CENTER		LL TRACE CIR /INGTON, IN 47408	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	Ι	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K0000					
		ode Recertification, State	K0000		
	_ ·	uality Assurance			
		ey were conducted by the			
		epartment of Health in			
	accordance with	42 CFR 483.70(a).			
	Cumian Data: 00	7/10/12			
	Survey Date: 09	9/18/12			
	Facility Number	·· 002574			
	Provider Number				
	AIM Number: 1				
	1111111110011				
	Survevor: Philli	ip Komsiski, Life Safety			
	Code Specialist	, ,			
	•				
	At this Life Safe	ety Code survey, Bell			
	Trace Health and	d Living Center was			
	found not in con	npliance with			
	Requirements fo	or Participation in			
	Medicare, 42 CF	FR Subpart 483.70(a),			
	Life Safety from	Fire, and the 2000			
	· ·	IFPA) National Fire			
		ciation 101, (LSC) Life			
	1 -	1410 IAC 16.2. The			
	original building	-			
	_	erything except the			
	Rehabilitation unit was surveyed with Chapter 19, Existing Health Care				
	Occupancies.				
	This one stars C	a ailite e vena a datai 1 4 -			
	1	acility was determined to			
	oe of Type v (T	11) construction and was			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

ALNY21

Facility ID:

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155677	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  01	(X3) DATE COMPL 09/18/	ETED
NAME OF PROVIDER OR SUPPLIER  BELL TRACE HEALTH AND LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  725 BELL TRACE CIR BLOOMINGTON, IN 47408				
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	alarm system wire corridors, spaces hard wired smok sleeping rooms. capacity of 80 ar the time of this s.  The facility was state law in regard and with smoke the customary access facility has one customage which wire customage which wire code Specialist-Me.  The facility was	found in compliance with rd to sprinkler coverage detector coverage.  the residents have swere sprinklered. The detached barn for facility as not sprinklered.  Robert Booher, Life Safety dical Surveyor on 09/24/12.  found not in compliance entioned regulatory					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ALNY21

Facility ID: 002574

If continuation sheet

Page 2 of 10

AND PLAN OF	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S				
155677		A. BUILDING 01 COMPLETEI 09/18/201					
155077			B. WIN			09/10/	2012
NAME OF PRO	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
REII TDA	CE HEALTH AND	LIVING CENTER			LL TRACE CIR IINGTON, IN 47408		
					1111GTON, 111 47408		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG					(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
K0051	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	BETTELENET,		DATE
SS=F	LIFE SAFETY CO	DDF STANDARD					
	A fire alarm syste						
	components, devi	ices or equipment is					
		g to NFPA 72, National					
		to provide effective					
		any part of the building. complete fire alarm system					
		alarm initiation, automatic					
		guishing system operation.					
	•	tient sleeping areas may					
	•	ed that manual pull					
		n 200 feet of nurse's tions are located in the path					
		onic or written records of					
	-	e. A reliable second source					
		led. Fire alarm systems					
		accordance with NFPA 72					
		aintenance are kept readily is remote annunciation of					
		tem to an approved central					
	station. 19.3.4,						
	Based on observa	ation and interview, the	K00	51	K 051 NFPA 101 LIFE SAFET	Y	10/18/2012
	facility failed to	install 1 of 1 fire alarm			CODE STANDARD It is the		
	systems in accord	dance with NFPA 72,			policy of Bell Trace Health &		
-	National Fire Ala	arm Code, 1999 Edition.			Living Center to maintain the rolling fire doors in accordan		
-	NFPA 72, 1-5.2.	5.2 requires the fire			with NFPA Code. 1. The fire	ice	
	alarm circuit disc	connecting means shall			alarm circuit disconnecting		
	have a red marki	ng, shall be accessible			means has been identified wi	-	
		ed personnel, and shall be			a red label stating "Fire Alarn	n	
	•	E ALARM CIRCUIT			Panel Shut-off". II. The		
	CONTROL. Thi	is deficient practice could			maintenance director provide an inspection of the circuit	₽d	
	affect all residents as well as visitors and				panel and no other fire system	m	
	staff.				disconnecting means were		
					found to be out of complianc	e.	
	Findings include	-			III. The Maintenance		
	a55c.aac	•			Department staff will inspect		
.	Based on observe	ation on 09/18/12 at 1:10			the facility circuit panel		
		ucion on o// 10/12 at 1.10			quarterly to ensure that fire		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ALNY21

Facility ID: 002574

If continuation sheet Page 3 of 10

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  IDENTIFICATION NUMBER:  155677	A. BUILDING  B. WING	ION	COMPLETED 09/18/2012
	PROVIDER OR SUPPLIER RACE HEALTH AND LIVING CENTER	STREET ADDRESS, 725 BELL TRAC BLOOMINGTON		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CROSS-I	ROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
	p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker was located in a utility room in the kitchen next to the kitchen exit, but it was not identified. Based on interview on 09/18/12 at 1:15 p.m. with the Maintenance Supervisor, it was acknowledged the breaker for the fire alarm system circuit was not identified.  3.1-19(b)	means labeled Depart require unders Mainte will rep to the l finding	system disconnecting are appropriately d. Maintenance ment staff will review ement and verify standing. IV. Inance Department state ort any non-compliar HFA who will bring the g to the facility's Quality ement Committee. V. LETION DATE:	aff nce e ity

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ALNY21

Facility ID: 002574

If continuation sheet

Page 4 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER:	A. BUILDING 01		01	COMPLETED	
155677		155677			·	09/18/	2012
			B. WIN				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
5511 75		LIN WALCO OFFITED			LL TRACE CIR		
BELL IRA	ACE HEALTH AND	LIVING CENTER		BLOOM	IINGTON, IN 47408		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	D PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0130	NFPA 101						
SS=E	MISCELLANEOU	IS					
	OTHER LSC DEF	FICIENCY NOT ON 2786					
	Based on observa	ation, interview and	K01	30	K 130 NFPA 101		10/18/2012
	record review; th	ne facility failed to ensure			MISCELLANEOUS		
		ntenance of 1 of 1 rolling					
		accordance with NFPA			It is the policy of Bell Trace		
					Health & Living Center to		
		equires any device,			maintain the rolling fire door		
		stem which is required for			in accordance with NFPA Co	de.	
	•	the provisions of this					
	Code, such device	ce, equipment or system			I. The contractor managing		
	shall thereafter be maintained unless the				the fire safety systems has inspected the rolling fire doo	_	
	Code exempts su	ich maintenance. NFPA			for appropriate operation and		
	-	, the Standard for Fire			is functioning properly.	<i>a</i> 10	
	·	Vindows, Section			lis functioning property.		
					II. There are no other rolling		
	-	s all horizontal or vertical			fire doors located within the facility.		
	-	ng fire doors to be					
	-	sted annually to check for			_		
	proper operation	and full closure.			III. The fire system contracto	r	
	Resetting of the	release mechanism shall			will continue to evaluate		
	be done in accord	dance with the			function of rolling fire door		
	manufacturer's ir	nstructions. A written			annually. Documentation of		
		naintained and shall be			the annual inspections will b		
					maintained in the Maintenand	ce	
		o the authority having			Department and will be		
	·	s deficient practice could			available upon request.		
		s present in the lounge			Maintenance Department sta	п	
	room adjacent to	the kitchen including			will review requirement and verify understanding.		
	staff or visitors.				verify understanding.		
					IV. The annual inspection of		
	Findings include	:			rolling fire doors will be adde	ed	
		-			to our facility Preventative		
	Racad on observe	ation on 09/18/12 at			Maintenance calendar in the		
					TELs maintenance software.		
	12:45 p.m. with t				HFA will monitor TELS tasks	to	
	Supervisor, there	was a rolling fire door			ensure that the rolling fire do	or	
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ALNY21

Facility ID: 002574

If continuation sheet Page 5 of 10

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
155677			B. WING 09/18/2012			
NAME OF PROVIDER OR SUPPLIER BELL TRACE HEALTH AND LIVING CENTER			725 BE	ADDRESS, CITY, STATE, ZIP CODE ELL TRACE CIR MINGTON, IN 47408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	the lounge room	pening from the kitchen to n without an attached		inspection is completed annually.		
	inspection tag. open to the corr on 09/18/12 at 1 Fire Safety reco with the Mainte acknowledged t documentation of test to check for	The lounge room was not idor. Based on interview 2:47 p.m. and subsequent rd review at 3:08 p.m. nance Supervisor, it was here was no additional of an annual inspection or proper operation and full ertical rolling metal fire		V. COMPLETION DATE: 10/18/2012		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ALNY21

Facility ID: 002574

If continuation sheet

Page 6 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	02	COMPL	
	155677		B. WIN			09/18/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
חבון דם	ACE LIEAL TH AND	LIVING CENTED			LL TRACE CIR		
BELL IK	ACE HEALTH AND	LIVING CENTER		BLOOM	IINGTON, IN 47408		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG K0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DE ICERCI)		DATE
Roooo							
	A Life Safety Co	ode Recertification, State	K00	000			
	Licensure and Q	·	1100	,00			
		y were conducted by the					
		partment of Health in					
	· '	42 CFR 483.70(a).					
	decordance with	42 CTR 403.70(a).					
	Survey Date: 09	0/18/12					
	Survey Bute. 09	,10,12					
	Facility Number:	. 002574					
	Provider Number						
	AIM Number: N						
	7 KIIVI I VUIIIOCI. I	171					
	Surveyor: Philli	p Komsiski, Life Safety					
	Code Specialist	p Komsiski, Life Safety					
	Code Specialist						
	At this Life Safe	ty Code survey, Bell					
		d Living Center Inc. was					
	found not in com	•					
	Requirements for	•					
	•	R Subpart 483.70(a),					
	· ·	Fire, and the 2000					
		FPA) National Fire					
	· ·	ciation 101, (LSC) Life					
		410 IAC 16.2. The					
		nit was surveyed with					
	Chapter 18, New						
	Occupancies.	TICALUI CAIT					
	Occupancies.						
	This one story fo	icility was determined to					
	1	•					
		11) construction and was					
		. The facility has a fire					
	aiaiiii system Wii	th smoke detection in the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ALNY21

Facility ID: 002574

If continuation sheet Page 7 of 10

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155677		(X2) MULTIPLE CO	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 09/18/2012	
	PROVIDER OR SUPPLIE	R	725 BE	ADDRESS, CITY, STATE, ZIP CODE ELL TRACE CIR MINGTON, IN 47408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	corridors, space hard wired smod sleeping rooms. capacity of 80 at the time of this.  The facility was state law in regard and with smoke.  All areas where customary access facility has one storage which with the aforem.	s open to the corridors and ke detectors in all resident The facility has a nd had a census of 71 at			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ALNY21

Facility ID: 002574

If continuation sheet

Page 8 of 10

i '		(X2) MULTIPLE CO		(X3) DATE SURVEY	
		A. BUILDING	02	COMPLETED	
155677			B. WING		09/18/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
		NAME OF STEP		LL TRACE CIR	
DELL IR	ACE REALTH AND	D LIVING CENTER		MINGTON, IN 47408	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG K0051	NFPA 101	CLSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)	DATE
SS=F		ODE STANDARD			
		em with approved			
		vices or equipment is			
		ng to NFPA 72, to provide			
		of fire in any part of the			
		ion of the complete fire by manual fire alarm			
	initiation, automa				
		stem operation. Pull			
		ted in the path of egress.			
		ten records of tests are			
		able second source of power			
		alarm systems are cordance with NFPA 72,			
		rm Code, and records of			
		kept readily available.			
		annunciation of the fire			
		an approved central station.			
	18.3.4, 9.6	votion and interview the	K0051	K OF A NEDA 404 LIFE OAFET	Y 10/18/2012
		vation and interview, the	K0031	K 051 NFPA 101 LIFE SAFET CODE STANDARD It is the	10/18/2012
	1	install 1 of 1 fire alarm		policy of Bell Trace Health &	
	1 -	rdance with NFPA 72,		Living Center to maintain the	
		larm Code, 1999 Edition.		rolling fire doors in accordar	
	· ·	.5.2 requires the fire		with NFPA Code. 1. The fire	
		sconnecting means shall		alarm circuit disconnecting	
		ing, shall be accessible		means has been identified w	
	1 -	ed personnel, and shall be		a red label stating "Fire Alarr Panel Shut-off". II. The	"
		RE ALARM CIRCUIT		maintenance director provide	ed
		nis deficient practice could		an inspection of the circuit	
	affect all resider	nts as well as visitors and		panel and no other fire syste	m
	staff.			disconnecting means were	
				found to be out of compliance	e.
	Findings include	<del>2</del> :		III. The Maintenance	
				Department staff will inspect the facility circuit panel	
	Based on observ	vation on 09/18/12 at 1:10		quarterly to ensure that fire	
	p.m., with the M	faintenance Supervisor		alarm system disconnecting	
	_	stem circuit breaker was		means are appropriately	
	1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ALNY21

Facility ID: 002574

If continuation sheet Page 9 of 10

PRINTED: 10/10/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155677	A. BUILDING  B. WING	(X3) DATE SURVE COMPLETED 09/18/2012	
	PROVIDER OR SUPPLIER RACE HEALTH AND LIVING CENTER	STREET ADDRESS, CITY 725 BELL TRACE O BLOOMINGTON, IN	CIR	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	DD EFIY (EACH CORR	RENCED TO THE APPROPRIATE	(X5) IPLETION DATE
	located in a utility room in the kitchen next to the kitchen exit, but it was not identified. Based on interview on 09/18/12 at 1:15 p.m. with the Maintenance Supervisor, it was acknowledged the breaker for the fire alarm system circuit was not identified.  3.1-19(b)	Departmer requireme understan Maintenan will report to the HFA finding to Improvement	ce Department staff any non-compliance who will bring the the facility's Quality ent Committee. V. ION DATE:	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ALNY21

Facility ID: 002574

If continuation sheet

Page 10 of 10